INSURANCE COVERAGE IN LONG-TERM HEALTH CARE FOR DEPENDENT PERSONS. *THE SCENARIO IN ITALY AND IN THE MAIN FOREIGN COUN-*

Coviello Antonio[1], Morana Fabrizio[2], Coviello Gerardo[3]

[1]*Ricercatore CNR-IRISS e Professore di Marketing Assicurativo, Università Suor Orsola Benincasa di Napoli*
[2]*Direttore Generale, Centro Studi AssicuraEconomia*
[3]*Ricercatore, Centro Studi AssicuraEconomia*

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ABSTRACT

urveying the elderly population appears to be strategic and decisive for the economy of a country. Deciding or planning how many years of work are sufficient to be able to retire, determining who will be affected by public health policies (e.g. exemptions for drugs and visits in certain income brackets) or free vaccination campaigns, are some examples of why there is such interest on the part of scholars, but above all on the part of governments who must make informed choices.
The aim of this work/report is to investigate the role of insurance companies and the Italian situation as regards long-term health care for dependent persons, as well as a comparison with other leading countries, such as the United States, the United Kingdom, France and Germany.

THE AGING OF THE WORLD POPULATION

By 2050, the world's elderly population will more than double from today's level, reaching 2.1 billion. That means there will be more than twice as many people over the age of 60 as there are children under 5 (Source: Visual Capitalist elaboration on United Nations data).
Then in 2020, more than 147 million people worldwide were between the ages of 80 and 99, or 1.9% of the world's population. The main reasons for the mass aging of the population are well known: progress in medicine and the spread of health facilities that have extended life expectancy, falling birth rates.
The World Health Assembly/World Health Assembly of the WHO in August 2020 launched the Decade of Healthy Ageing 2020-2030. It aims to improve the lives of older people by implementing coordinated policies in four directions: changing the way we think about aging, developing communities in ways that promote older people's capacity for independence, providing integrated person-centered care and primary health care services that meet their needs, and providing older people who need them with access to quality long-term care.
Defining quantitatively who the elderly are is crucial for the economy of a country: it means, for example, deciding how many years of work are sufficient to be able to retire, but also establishing who will be affected by public health policies (for example, exemptions for drugs and visits in certain income brackets) or free vaccination campaigns. In 2018, Italy's pension spending (including the welfare component!) was 293 billion euros, or 16.6% of GDP, or 34.3% of public spending (Istat data January 2020). We have therefore spent almost three times as much on pensions as we do on healthcare and almost five times as much on education and research.

THE ROLE OF INSURANCE

The Geneva Association (founded in 1973, it is the only global association of insurance companies) published a report in August 2021 on the role the insurance industry can play in meeting the new healthcare needs arising from an ageing population. This is the definition of New Care Models/How insurers can rise to the challenge of older and sicker societies.
Demographic and epidemiological changes have meant that chronic and age-related diseases now account for a large proportion of healthcare spending. Specialty and hospital care are prevalent in most health care systems, and changes in consumer needs warrant greater convergence of all levels of health and social care in order to improve patient experience and outcomes and control cost inflation. The latest World Health Organization Report shows that global spending on health has continuously increased between 2000 and 2018 and reached $8.3 trillion or 10% of global GDP.
Unlike traditional care approaches, the proposed New Care Models-NCMs seek to better coordinate the elements mentioned above with each other. NCMs can take many forms but what they have in common is: an emphasis on prevention and health promotion, proactive chronic disease management, collaboration between health and social care to address multiple comorbidities, and seeking home-based alternatives to hospitals or long-term residential care. The Report highlights how health and life insurers can adopt NCM models to impact health care across all stages of life seamlessly and to control related costs.

LONG TERM CARE INSURANCE IN ITALY

Article 2 of our Code of Private Insurance (Legislative Decree no. 209 of 7 September 2005) classifies in the IV Branch of Life Insurance "health insurance and in-

surance against the risk of non-self-sufficiency which are guaranteed by means of long-term contracts, not subject to cancellation, for the risk of serious invalidity due to illness or accident or longevity": in essence, these are the so-called Long Term Care policies. Very briefly, coverage is acquired for expenses deriving from the impossibility of autonomously carrying out the normal functions of daily life, with consequent impairment of self-sufficiency, not necessarily due to illness or accident, but also to senescence. The policy, therefore, is purchased to protect against these situations that may occur, particularly in old age, when it is particularly useful to have a sum to pay a carer or a nursing home or to have the necessary assistance.
According to ANIA data (Premiums of Italian Direct Business 2020, Edition 2021), in 2020 these policies (contained in the "Health" segment of the Life Business) collected 180,640,000 euros, with an increase of 21.2% compared to the previous year, through 27 Companies. 46% of premiums were collected by Agents, 36% by Brokers and the remainder was divided between Direct Sales, Financial Advisors/Mobile Brokerage Companies and Bank Counters.

INTERNATIONAL SYSTEMS OF LONG-TERM CARE FOR DEPENDENT PERSONS

United States of America

In the United States the entire health-care sector is privatized and therefore there is no free medical care: the state does not own any health-care facilities.
There is no free medical care: the state does not own any medical facility. There is no national healthcare system and every single citizen is obliged to have his or her own health insurance, which he or she can choose from the proposals of the various private companies present on the territory.
In most cases, private insurance policies are taken out through one's employer: the larger the company that employs one, the more likely it is to offer this benefit to its employees. The larger the company you are employed by, the more likely it is that it will offer this benefit to its employees. Generally, companies enrol their employees in a Health Maintenance Organization HMO - an autonomous health fund - whose main purpose is to provide a range of health services against payment of an annual fee and which usually has affiliated facilities.
The only forms of health care in the United States prior to Obamacare were the Medicare and Medicaid programs:

- Medicare is the only universal and uniform program aimed exclusively at individuals over the age of sixty-five and young people with work-relevant disabilities.
- Medicaid provides assistance to certain categories of the poor such as children, family members, persons with disabilities, the elderly with minimal incomes, and persons with high medical expenses. The program is subsidized by mixed federal and state contributions and assists over 40 million citizens.

In 2010, President Barack Obama introduced the health care reform called Obamacare (Patient Protection and Affordable Care ACT/ Act), with the aim of increasing the number of people protected. The main targets were unemployed, precarious workers, people whose salaries were particularly low but not very low, or citizens with a disability or family obligations that did not allow them to work full-time, with difficulty securing good, affordable health insurance. In May 2017, President Donald Trump had the House of Representatives pass a request to repeal Obamacare: however, the proposal was rejected by the Senate (despite a Republican majority), but Trump later passed some specific changes to Obama's reform anyway. With President Biden recently elected, the situation seems to be evolving further.

United Kingdom

In the United Kingdom, the National Health System NHS is responsible for the provision and financing of social and health services for the entire population. population.
Annually, the English government establishes the budget for public spending on the NHS but, due to the high level of care provided, the system is experiencing a moment of crisis. Because of the long waiting times, citizens with medium-high incomes often prefer to take out personal insurance and more and more employers are providing their employees with private insurance coverage.
In 1999, the National Care Standards Commission was established.
NCSC and the National Minimum Standards NMS for Long Term Care Residences and Home Care were published, detailing how to meet the needs of caregivers, how to meet the needs of patients, and how to meet the needs of the community. detailed descriptions of how to meet the needs of caregivers, procedures for minimizing care-related risks, and the characteristics of staff assigned to care activities. characteristics of the staff assigned to care activities. In particular, in the area of non-self-sufficiency, the English State provides people who lose their autonomy with a financial contribution that comes in two forms:

- Disability Living Allowance, guaranteed to persons who are less than 65 years of age.
  Disability Living Allowance, granted to persons under the age of 65 who, because of illness or injury, require assistance with mobility and self-care issues.
- Attendance Allowance, guaranteed to persons who are 65 years of age or older and who need assistance due to physical or mental illness or disability.

France

In France, the healthcare system is a mixed one, as it provides for a plurality of public and private operators, both in terms of financing and in terms of service provision. There is a Universal Social Insurance divided into various sickness funds for categories of workers, which reimburses (in whole or in part) the expenses sustained by the insured and dependent family members. Registration is compulsory and the contribution, divided between worker and employer, is commensurate with the employer, is commensurate with income. The share of health expenses not reimbursed is instead borne by the user, who can enter into private insurance contracts with Mutual Societies or Insurance Companies.
As far as assistance for the non-self-sufficient elderly is concerned, the problem has been regulated by

a law of 2001: the Allocation personnalisée d'autonomie APA (Personalized Autonomy Allowance). Benefits are supplied by means of a cash contribution aimed at the acquisition of assistance services, both for home care and for the payment of residential care. The degree of self-sufficiency is measured by making use of a grid called Autonomie Gerontologique Groupe Iso-Resources AGGIR, with the The degree of self-sufficiency is measured by using a grid called Autonomie Gerontologique Groupe Iso-Resources AGGIR, with the use of 17 variables: only those who fall within the first four groups are eligible for APA. A maximum monetary disbursement is foreseen for each of the There is a maximum monetary disbursement for each of the four degrees of non-self-sufficiency and the benefit is reduced according to income: a person with a very high income receives only 10% of the maximum monetary value of his or her degree of disability.
The verification of the conditions of eligibility is entrusted to an special social-healthcare team that determines the state of need of the elderly person, including their social conditions (informal help informal aid, housing conditions) and formulates a "plan of help" to determine the hours of assistance the elderly person needs. to determine the hours of assistance the patient needs. Non-self-sufficient elderly persons who remain in their own homes may employ one or more persons whose remuneration may be paid by the State directly to the caregiver or credited monthly to the assisted person's bank account. For those who are hospitalized in residential structures, the contribution is instead paid directly to the structure for the coverage of the daily fee predefined at the national level.

Germany

In Germany, the healthcare system based on the Bismarkian Model was created to guarantee citizens against a series of risks such as guaranteed pensions, accidents and inability to work, unemployment, illnesses requiring long-term care. The healthcare system is based on a compulsory insurance for all residents and such that coverage is universal: it cannot be waived and everyone must be covered in some way either with a compulsory "public" social insurance accessible to all or with a "private" one accessible under certain conditions. Germany set up in 1995 a Public Fund for Assistance to the Non-self-sufficient in order to meet the ever-increasing need for assistance. Thus, a new pillar has been created in addition to the four mentioned that historically characterize German welfare. In concrete terms, Pflegeversicherung intends to guarantee services independently of the income or assets of those assisted, focusing mainly on prevention and rehabilitation as well as home care. It supports the availability of commitment on the part of family members and citizens with an income of less than approximately 3500 euros per month must compulsorily insure themselves with the public fund. In the case of employees, the contribution is paid for half by them and the other half by employers and the period of need must cover a sufficiently long time and in any case not less than 6 months.
Pflegeversicherung beneficiaries are caregivers of any age who, as a result of an illness or form of disability, are incapable of performing some or all of the basic functions of daily living (Washing, dressing/undressing, feeding, toileting, moving around). Coverage was expanded in 2017 to include people in need of assistance as a result of mental and physical illness. Caregivers can choose from several benefits that provide different coverage depending on the level of non-self-sufficiency: home care, residential care, cash contribution combined cash and in-kind benefits. The entities entrusted with the management of the Assistance Fund are the Assistance Funds, autonomous non-profit public-law entities endowed with managerial autonomy, subject to public supervision and set up within the Mutual Health Funds. Each Mutual Health Fund has constituted within its own structure a Fund of assistance for non-self-sufficiency in favor of its own members, managed by its own administrative personnel. The Funds and the Funds therefore have the same management bodies, administrative staff and medical service and are subject to the same public supervision. At the end of 2018, there were about 3.7 million beneficiaries, with about 80% in home care and the remaining 20% in nursing homes. (Source: ERC Centro Europa Ricerche - Non-self-sufficiency insurance in Germany).
Below is an overview of insurance benefits in Berlin in 2019 (Source: ERC elaborations on data from Bundesministerium für Gesundhei-Federal Ministry of Health):

1. Personal care
2. Advanced personal care (without bathroom, with bathroom)
3. Help with feeding
4. Help with leaving/returning to the home
5. Accompaniment outside the home
6. Heating the apartment
7. Cleaning the apartment
8. Laundry and clothes care
9. Shopping
10. Preparing a hot meal at home
11. First visit.

The situation in Italy

In Italy, the National Health Service (SSN) was established by Law n. 833 of 23 December 1978 and our model gives citizens the freedom to choose the provider of the assistance service. The Ministry of Health - through the National Health Plan - determines the Essential Levels of Care (LEA) to be guaranteed to citizens in a uniform manner throughout the national territory. It is the task of the Regions to implement the Essential Levels of Care according to the needs of the local population, to organize the services, provide the services and establish the financing criteria.
The State provides the principal directives in matters of health and assistance, controls the uniformity of treatment, allocates the resources of the National Fund for Social Policies and directly dispenses cash benefits in support of the elderly and the disabled. The treatments programmed and regulated by the Regions consist of Social Allowances or Vouchers, Socio-sanitary Vouchers and the Fund for Non-self-sufficiency. At the local level, the Asl (local health authorities) and the municipalities are responsible for the provision of health services and social-sanitary services, and in the complex of services that characterize Long Term Care, multiple public and private operators are involved (from the profit and non-profit sectors and

home care providers "carers"), with different and often overlapping competencies, defined at the legislative level.
Care is defined as informal when it is provided by people such as family members, friends or neighbors, who represent the core of support available to the vast majority of the elderly in Italy. If the care is provided by a nurse, a doctor or any other professional, the assistance is called formal.
Formal care is divided into Domiciliary (Home care with a social character/Home care with medical and/or nursing assistance) or Residential (RA: care residences oriented to respond to needs of a prevalently socio-assistance nature and intended for subjects with a good degree of self-sufficiency/RSA: residences oriented to respond to health needs combined with a different degree of social need).

The Commission for the Reform of Health Care and Sociomedical Assistance for the Elderly Population

ISTAT and the Commission for the reform of health and socio-sanitary assistance for the elderly population established at the Ministry of Health and chaired by Monsignor Vincenzo Paglia have started a collaboration to explore the conditions of fragility and the demand for social and health care expressed by people aged 75 and over. In June 2021, the Report "The elderly and their social and health demand year 2019" was published, which identifies on a reference population composed of about 6.9 million over 75, more than 2.7 million individuals who present serious motor difficulties, comorbidities, impairment of autonomy in daily activities of personal care and instrumental activities of daily life. These segments of the population are those that most urgently require intervention, or else the explosion of the related health demand in the form of access to emergency departments, hospitalizations, use of drugs and visits, access to RSA, etc.
In September 2021, the Charter of the Rights of the Elderly and the Duties of Society was presented to Premier Draghi. Monsignor Vincenzo Paglia, who presides over the Commission for the reform of health care and social assistance for the elderly population, established at the Ministry of Health, as well as President of the Pontifical Academy for Life, on the occasion wanted to declare that "The proposed reform "represents a true Copernican revolution, the reversal of a paradigm that wants the elderly marginalized from the vital flow of society, an irrelevant element of existence, waste and weight for those who are not elderly. The pandemic has revealed in all its harshness the dramatic consequences. On the contrary, we want the elderly at the center, in their homes, in the neighborhoods, in the suburbs of big cities as well as in the municipalities of the internal areas at risk of depopulation", just to prove the importance and delicacy of the subject matter.

CONCLUSIONS

The ageing of the population will amplify the number of applicants and the costs for the management of benefits. It would be opportune to evaluate forms of collective obligatory insurance, as we have seen in the German example, with desirable joint public-private financing. The younger population should be made more aware of the issues involved, encouraging the creation of private financial resources for this purpose, perhaps beginning to include Long Term Care coverage in existing Welfare structures. The resources earmarked for the National Recovery and Resilience Plan PNRR represent an extraordinary tool for achieving great progress in this area.

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